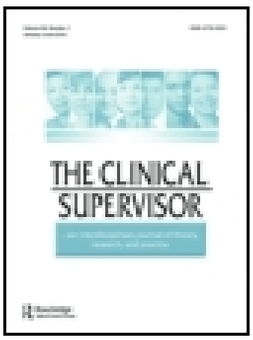

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Experiential supervision: healing imposter phenomenon from the inside out

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Experiential supervision: healing imposter phenomenon from the inside out

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ABSTRACT

Psychotherapists acquire skills in high stakes environments while actively treating clients in distress. The natural disparity between skill mastery and client need can affect neophyte and experienced clinicians alike. Left unaddressed, self-doubt and emotional dysregulation can escalate to imposter phenomenon, a debilitating mental state marked by feelings of incompetence, failure, and professional fraudulence. Although recent studies have examined the impact of imposter phenomenon upon psychotherapists, few have provided an evidence-based approach to supervision to address it. This article presents a case report to illustrate the integration of narrative therapy and interpersonal neurobiology into clinical supervision to alleviate imposter phenomenon.

KEYWORDS

Imposter phenomenon; psychotherapy supervision; narrative therapy; interpersonal neurobiology

Introduction

Psychotherapists learn in real time and must make decisions with potentially life altering consequences affecting clients in distress. In vivo skill acquisition juxtaposed with active client treatment can be emotionally challenging for neophyte and experienced clinicians alike. Without intervention, self-doubt, and emotional dysregulation in these learning situations can escalate and cause clinicians to experience imposter phenomenon. Clance and Imes (1978) defined imposter phenomenon as an internalized mental state marked by feelings of incompetence and shame, as well as the belief one is a fraud. A consistent finding related to imposter phenomenon is the propensity for sufferers to reject all factual evidence of their competence and attribute their success to luck or error (Clance & Imes, 1978; Clance & O'Toole, 1987). Literature documenting the adverse emotional effects of imposter phenomenon in medicine and nursing is extensive. However, studies investigating the impact of imposter phenomenon upon psychotherapists is scarce. Moreover, though supervision is an integral source of professional and emotional support for clinicians, methods to address imposter phenomenon in clinical supervision are completely absent in the literature.

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In this paper, I examine the efficacy of incorporating narrative therapy and interpersonal neurobiology into psychotherapy supervision to alleviate imposter phenomenon. The relational and experiential nature of narrative therapy has prompted an investigation into how narrative therapy supports neuroplasticity (Zimmerman, 2017), the brain's capacity to rewire itself and change (Cozolino, 2002, 2006; Schore, 2014; Siegel, 2012). With this hypothesis in mind, the case report illustrates the integration of narrative therapy and interpersonal neurobiology into the supervisory relationship. The intended result of supervision is to deconstruct internalized fraudulence, help clinicians reclaim their lost sense of agency, facilitate learning, and ameliorate imposter phenomenon (Miehls, 2014; Zimmerman, 2017). Methods to ensure an explicit boundary between clinical supervision and psychotherapy are identified and limitations and suggestions for future research are discussed.

Literature review

Imposter phenomenon

Imposter phenomenon has been studied for more than four decades. The syndrome was identified and defined by Clance and Imes (1978) in a landmark study of 150 White women. All of the study participants held either a master's or doctoral degree, achieved high standardized test scores, and held professional positions of importance in business and academia. Through observation, qualitative interview, and anecdotal reporting, Clance and Imes (1978) investigated participants' perceptions of their intelligence and legitimacy in their respective fields. Despite significant evidence, all of the women universally believed they were not intelligent. They credited their achievements to luck or error, suffered deep shame, and reported living in fear that their perceived fraudulence would be discovered by peers (Clance et al., 1995; Clance & Imes, 1978; Clance & O'Toole, 1987). The capacity of the study participants to invalidate their prior achievements was stunning. The incongruence between the participants' demonstrated expertise and internalized fraudulence led to multiple investigations spanning four decades.

In subsequent studies, researchers examined family-of-origin in an attempt to understand the genesis of the distorted self-perceptions inherent to imposter phenomenon (Langford & Clance, 1993). They found that as children, all participants were either pressured to attain perfection or routinely compared to an idealized sibling by their parents (Clance et al., 1995; Langford & Clance, 1993). Although it is unlikely every person with similar childhood experiences would develop imposter phenomenon, these two scenarios were consistent enough for researchers to infer correlation (Clance et al., 1995; Clance & Imes, 1978; Clance & O'Toole, 1987; Langford & Clance, 1993). However, the proposed links between imposter phenomenon and familial influence were

restricted due to the small study samples of 150 or less, the narrow foci on white women, the exclusion of men, and the absence of consideration for race, ethnicity, and socio-economic status as factors of significance (Clance et al., 1995; Clance & Imes, 1978; Langford & Clance, 1993). Though limited, these early studies brought an otherwise undefined, unexamined, adverse human experience into the psycho-social research milieu.

Recent investigations have examined the relationship between imposter phenomenon and gender. Badawy, Gadzag, Bently and Brouer (2018) found that imposter phenomenon occurs with similar frequency among men and women, with nearly identical symptoms. The only difference noted between genders was the lesser likelihood of men to disclose their struggle, perhaps due to gender stereotypes equating vulnerability with weakness (Badawy, Gazdag, Bentley & Brouer, 2018; Hoang, 2013). It should be noted that studies examining imposter phenomenon correlate strong racial identity with a reduced incidence of imposter phenomenon among minority groups (Bernard, Hoggard & Neblett, 2018). It is possible minority groups may place a higher value on how they are seen within their own communities more than how they are regarded by the dominant groups. Conversely, having had a prior experience of racism increased the likelihood of imposter phenomenon when engaging professionally with majority groups (Bernard et al., 2018; Cokley et al., 2015). Further examination of minority status and its relationship to imposter phenomenon is necessary to understand this dichotomy.

As empirical investigations of imposter phenomenon expand, its universality becomes clear. The risk for imposter phenomenon is much broader than initially thought and affects people across gender, race, level of education, and family of origin (Badawy et al., 2018; Bernard et al., 2018; Cokley et al., 2015; Hoang, 2013; Bernard, Hoggard & Neblett, 2018). Researchers in medicine, psychology, and social work have begun investigating how professional environments might trigger imposter phenomenon (Gibson, 2014; Urwin, 2017). Though not yet studied, practicum learning settings where instruction and treatment of vulnerable stakeholders occur simultaneously is one such environment.

Learning environments and imposter phenomenon

Whether student, intern, or licensed professional, environments where learning and treatment of vulnerable patients happen concurrently place a unique pressure upon helping professionals. Imposter phenomenon is well documented in medicine affecting direct care professionals (Swope et al., 2017). LaDonna et al. (2018) noted imposter phenomenon in physicians across all areas of medical specialization. They found that imposter feelings lessen as professionals gain clinical experience; however, even in highly experienced medical professionals, a mid-to-late career transition into a new specialty can

trigger a recurrence of imposter phenomenon. These findings are significant and support the proposition of this paper. Learning environments where a substantive disparity exists between skill mastery and client risk can trigger imposter phenomenon. Unequivocally, there is a narrow margin of error where a mistake made in the natural course of clinical learning can be deadly.

Like medical professionals, psychotherapists learn in vivo. Both neophyte and experienced clinicians must tolerate disparities between skill mastery and client need as they pursue new knowledge and skills (Urwin, 2017). While in training, psychotherapists treat clients struggling with serious mental illness, addiction, child protection investigations, and numerous issues posing risk to their clients (Gibson, 2014). The pressure to make the correct decision on behalf of vulnerable clients is significant, and over time may trigger imposter feelings (Urwin, 2017). This view supports the theoretical proposition of Slank (2019), whereby imposter phenomenon may be deemed as warranted rather than pathological. This stance is suggestive of a research trend that looks beyond internal causality and examines how professional situations can trigger imposter symptomatology. Slank (2019) posited that feelings of inadequacy should be expected in environments wherein one's talent level is incongruent with requirements and expectations of the professional role. Moreover, she normalized imposter phenomenon as a natural and expected part of in vivo learning.

Emotional impact of imposter phenomenon

Imposter phenomenon has retained interest as a vital area of scholarly inquiry for over four decades. Its longevity as a topic may be attributable to a persistent interest in preventing and alleviating the impact imposter phenomenon has upon those affected. As discussed, the circumstances predictive of imposter phenomenon are variable and have changed over time, yet the adverse emotional experiences associated with it have remained constant (Clance et al., 1995; Clance & Imes, 1978; Cokley et al., 2015). Imposter phenomenon is associated with the onset of intense anxiety and episodes of panic, depression, and burn-out (Thériault & Gazzola, 2010; Thériault et al., 2009). As shame intensifies, distorted thoughts such as "I am a fraud" are exacerbated (Cozzarelli & Major, 1990; Thériault & Gazzola, 2010).

Allan et al. (2016) investigated levels of shame in participants learning a new, evidence-based model of psychotherapy. The male and female therapists had one to 40 years of experience. Through a series of qualitative interviews, observation, and anecdotal reporting, participants described feelings of inadequacy and high shame levels as they encountered difficulty applying the new model to their clients. There is also evidence that experienced psychotherapists are less likely to disclose imposter feelings, thus causing profound isolation and increased shame (Allan et al., 2016; Perret, 2017;

Yourman, 2003). Clinicians experiencing imposter phenomenon also have reported emotional withdrawal from their clients and premature termination, both of which negatively impacted clients (Allan et al., 2016; Cozzarelli & Major, 1990; Thériault & Gazzola, 2010; Thériault et al., 2009). Though these studies were relatively small, findings were consistent in terms of participants' level of emotional dysregulation (Allan et al., 2016; Cozzarelli & Major, 1990; Thériault & Gazzola, 2010; Thériault et al., 2009). The need to address the negative impact of professionally triggered imposter phenomenon upon psychotherapists is clear.

The supervisory relationship

As psychotherapists continue to learn in practicum settings, providing them with a safe space to address clinical learning concerns and obtain emotional support is imperative. The supervisory relationship is an integral part of healing imposter phenomenon. Johnson et al. (2018) viewed the supervisory relationship as a continuum of mentorship. Mentoring begins with transactional-didactic quality wherein the supervisor teaches and leads as the supervisee acquires knowledge and skills. It fosters a transformative-confidence building quality by which the supervisee can take risks in service of professional growth. Privileging the supervisory relationship fosters a relational bond where vulnerability, countertransference, in-session triggers, and most importantly, imposter feelings may be explored and addressed in context (Beinart & Clohessy, 2017).

A significant component of the supervisory relational alliance is emotional self-disclosure by the supervisor. Knight (2012) conducted a comprehensive review encompassing multiple studies to examine how supervisor disclosure impacts the supervisor-supervisee dyad. Knight (2012) asserted emotional disclosure on the part of the supervisor makes it more likely a supervisee will disclose mistakes and seek emotional support when they are struggling. Supervisors who honor their supervisees' emotional experience give rise to a supportive learning relationship that transcends the limitations of a purely didactic approach. Explicit discussion of a supervisee's affective responses ensures that clinical trainees do not suppress the emotional distress that can lead to imposter phenomenon and adverse client outcomes (Cozzarelli & Major, 1990; Ingram, 2013; Thériault et al., 2009). Finally, when supervisors disclose their own emotions and share their prior experiences of shame and inadequacy, it creates a bond between supervisor and supervisee through their shared vulnerability.

The supervisory relationship normalizes the supervisee's struggle, models an emotionally intelligent and ethical use of self by the supervisor, and builds the alliance necessary to safely explore imposter vulnerability, while restoring professional resilience (Ingram, 2013; Perret, 2017). As conceptualized by this

writer, explicit emotional engagement, supervisor self-disclosure, and a stance of curiosity and compassion comprise the foundational core of the supervisory dyad (Frawley-O'Dea & Sarnat, 2001; Knight, 2012; Prenn & Fosha, 2017). These objectives are not new to supervision. However, when experienced through the lens of neuroscience (Schore, 2014; Siegel, 2012), they have the power to be transformative (Egan, Neely-Barnes, & Combs-Orme, 2011; Johnson, 2006; Miehls, 2014).

Narrative therapy, interpersonal neurobiology, and clinical supervision

In order to fully grasp the intentionality of the supervision process illustrated in the case report presented, it is necessary to possess a basic understanding of neuroscience as it relates to interpersonal neurobiology (Cozolino, 2006; Schore, 2014; Siegel, 2012). Neurons are the brain's information conductors. They fire when people engage with one another and with their environment (Cozolino, 2006). When triggered, the brain's emotional center, or limbic system, engages the amygdala and activates the fight, flight, or freeze response (Cozolino, 2006). If the nervous system designates a stimulus a threat, multiple systems in the body engage and prepare it to respond and survive (Cozolino, 2006). In direct contrast, interpersonal bonding causes the nervous systems to release neurochemicals telling the body it is safe and well, creating balance, and allowing the nervous system to engage in non-survival driven responses, one of which is learning (Cozolino, 2002; Shapiro & Applegate, 2018; Siegel, 2012). Repeated experiences, whether positive or negative, cause the brain to adapt and change throughout the life cycle (Cozolino, 2002; Fishbane, 2007; Schore, 2014; Siegel, 2012). This process is known as neuroplasticity (Cozolino, 2002; Siegel, 2012) and is the foundational theory upon which interpersonal neurobiology is based (Cozolino, 2002; Fishbane, 2007; Schore, 2014; Siegel, 2012).

The supervisor choreographs new experiences with the supervisee. The objective is to engage the nervous system to create an imprint of the experience. In neurobiology, this process creates a new neural pathway (Cozolino, 2002; Egan et al., 2011; Siegel, 2012). Theoretically, as positive emotional engagement occurs within the supervisor-supervisee dyad, the brain strengthens these new neural pathways, causing the negative emotional pathways to lessen (Cozolino, 2002; Miehls, 2014; Prenn & Fosha, 2017: Schore, 2014; Siegel, 2012). The supervisory relationship and experiences within it may have the capability to evoke changes in the brain to counter and heal internalized states of shame, fear, and incompetence inherent to imposter phenomenon (Egan et al., 2001; Johnson, 2006; Miehls, 2014).

According to Cozolino (2006), the care and support of the mentor supervisor is transmitted through mirror neurons in the frontal cortex of the brain, which enables us to experience empathy. This neurobiological process

supports the concept of supervisory immediacy presented by Prenn and Fosha (2017). Supervisory immediacy proposes that when supervisor and supervisee share their in-the-moment emotions, right-brain to right-brain transformative experiences can happen (Cozolino, 2002; Schore, 2014; Siegel, 2012). Dyadic connection engages the nervous system (Cozolino, 2002; Miehls, 2014; Siegel, 2012), incites neuroplasticity (Cozolino, 2006; Shapiro & Applegate, 2018), and deepens the corrective emotional experience of supervision (Prenn & Fosha, 2017). The supervisor must tether the supervisee's emotional experiences back to the client and case details. Connecting the supervisee's experience to the interventions used with the client reinforces the explicit teach-treat boundary between psychotherapy and supervision (Frawley-O'Dea & Sarnat, 2001; Prenn & Fosha, 2017). As supervisor and supervisee engage relationally, emotionally, and somatically, the new story of competence and resilience may begin.

The techniques used in narrative therapy are both relational and experiential. Narrative therapy is a powerful approach to psychotherapy. Narrative therapy seamlessly incorporates the best practices of supervisory mentoring (Beinart & Clohessy, 2017) to create a ripe field of experience between supervisor and supervisee to foster neurobiological shifts (White & Epston, 1990; Zimmerman, 2018; Zimmerman & Beaudoin, 2015). Narrative therapy espouses a non-pathologizing stance and honors clients as separate and distinct from their problems (Carr, 1998). The narrative therapist explores the lived experiences of clients and adopts a collaborative, non-hierarchal stance whereby she becomes a consultant or witness to the client's internalized stories. White and Epston (1990) theorized that emotional and psychic distress connect to painful, internalized life stories that do not accurately depict the individual's lived experience. Nonetheless, these oppressive stories are internalized as true and cause suffering. As a result, these pathologizing narratives become the dominant story for the client and a substantial part of their perceived identity (Carr, 1998). An important narrative therapy technique is externalizing the problem to create a perceptual separateness between the person and the presenting issue (Carlson & Erickson, 2001). Using gentle questions, the therapist guides the client toward externalization, which is a separation or boundary between the person and the problem (Carr, 1998). Likewise, when helping a clinician work through imposter feelings, the supervisor might ask, "How is the fraud making it hard for you to enjoy your work?" This question objectifies fraudulence as a separate entity and an external rather than internal force.

As narrative therapy evolves, the therapist guides the client toward locating times in her life when she was not marginalized by the problem at hand. Together, they begin to create a new narrative (Carr, 1998). The therapist expands and connects the narrative to other lived events while tracking emotion arising from the telling of the new story, or re-storying (Carlson

& Erickson, 2001). As this process intensifies, a new, affirming story can overpower the oppressive, maladaptive narrative (Zimmerman & Beaudoin, 2015). Connecting bodily sensation, emergent primary affect, and memory to the new narrative creates a phenomenological shift. According to Beaudoin and Zimmerman (2011), narrative therapy supports neuroplasticity by the "storing and storying of experience" (p. 56). They propose that the moment-to-moment experience between therapist and client, and the dyadic, somatic, psychic, and emotional engagement around the newly constructed narrative, facilitate right-brain to right-brain resonance (Zimmerman & Beaudoin, 2015). The suppositions above connect to the theory of neuroplasticity held by Cozolino (2006), Schore (2014), and Siegel (2012) wherein mirror neurons fire in response to the interpersonal experience. Zimmerman and Beaudoin (2015) maintain that the shared experience of the new, positive narrative becomes the catalyst for neurobiological activation and transformative healing. Indeed, more extensive research would be needed to show correlation, yet the proposition that narrative therapy supports neuroplasticity, engenders right-brain to right-brain experiences, and potentially cultivates transformational healing on an interpersonal, cognitive, emotional, and neurobiological level (Zimmerman, 2018; Zimmerman & Beaudoin, 2015) is truly a compelling one.

The internalized narrative of imposter phenomenon tells a story of incompetence and shame. It is a story where fear and fraudulence block out lived experiences of pride and competence in favor of a narrative that perpetuates failure and disgrace. The case report that follows relies upon narrative therapy and interpersonal neurobiology to facilitate attunement, engender resonance, externalize the imposter, and mentor the struggling supervisee. Together, supervisee and supervisor explore lived experiences so the supervisee may reclaim her disowned competence and move toward a new, more adaptive healing narrative.

Case report

I am a licensed clinical social worker specializing in couple therapy with clients experiencing complicated grief and relational trauma. I also provide supervision and training to clinicians learning relationship therapy. Over the past 16 years, I have observed the incidence of imposter phenomenon among supervisees working with this highly vulnerable population. As a result, I began developing a model of supervision to alleviate imposter phenomenon. Below, I present a composite case vignette illustrating supervision with "Anna." This composite case combines the qualities and actual experiences of multiple participants to create a hypothetical case example. This approach affords a clear demonstration of supervision techniques through a real-world

context while providing complete anonymity for the participants from which the case report was drawn (Duffy, 2011).

When I met Anna for our first supervision session, I was struck by her almost colorless blue eyes beautifully framed by her cropped white hair. She conveyed a quiet elegance. Her composure and demeanor were highly incongruent with the "abject failure" she described herself to be when we first spoke on the phone. Since Anna was self-referred for individual supervision, I started by asking how she thought I might be helpful to her. Anna's posture immediately fell and her eyes filled with tears. Since starting her training and practice with couples, Anna had become overwhelmed by feelings of incompetence and suffered from insomnia, stress headaches, and stomach upset. She felt overtaken by shame and worried her inexperience might cause unintentional harm to her clients (Clance & Imes, 1978). Anna coped with her distress by canceling sessions and terminating therapy prematurely, and was well on her way to burn out. I listened and gave Anna plenty of space to share her history, her pain, and her needs.

Anna started training in couple therapy after a twenty-year career working with children. She was married and had a college-aged son. Her father emigrated from South Africa and her mother came from Poland as a child fleeing the Holocaust. Anna's parents divorced when she was ten and her father returned to South Africa. Anna was left with her mother who struggled with depression. She saw herself as "a survivor" who was an excellent student and had many friends. Anna described her faith and involvement in the Jewish community as a stable force in her life and credited a caring therapist as having helped her heal from her family of origin traumas. Anna told me she had never before experienced anything like the distress she felt since starting couple therapy training and practice.

The first step in any supervisory relationship is creating safety. It was clear Anna had been holding in her imposter feelings for some time. In keeping with the narrative therapy precept of "client as the expert," I let her lead in order to establish a non-hierarchal alliance (White & Epston, 1990; Zimmerman, 2018). Narrative therapy also holds that a person's lived experience is as valuable as formally acquired knowledge and experience. I made it clear that I viewed Anna's lived experiences as essential to supervision and tantamount to my knowledge and skills as a clinician and supervisor (Carlson & Erickson, 2001).

Anna spoke continuously for most of our first meeting. She vacillated between belittling her couple work and denigrating her former practice with children. She asked, "How hard is it to play Guess Who? That is not the work of a real therapist." Without waiting for me to respond, Anna bounced right back to her litany of couple therapy failures. With a few minutes left in our meeting, she stopped suddenly and apologized. "I am all over the place. I don't think I am cut out to do therapy with anyone feeling like this." As she spoke,

Anna's breathing became shallow and her face flushed. As noted by Cozolino (2006) and Shapiro and Applegate (2018), these somatic markers were indicative of neurobiological activation. Anna was shifting from anxious venting to shameful incompetence and despair.

As noted by Johnson et al. (2018), a viable mentorship is not only didactic, but reciprocal, since empathy and compassion are the drivers of the supervisory relationship and the conduits to learning. Honoring Anna's vulnerability by validating her struggle was essential to creating security in our professional relationship I leaned forward and in a soft voice said, "Anna, I remember feeling so lost when I started this work. I never felt good enough, and trial and error learning just made me feel worse." Although this disclosure is a seemingly small one, its intention is powerful. Sharing my own struggle was intended to normalize and de-pathologize Anna's. Here, I used self-disclosure with a relational, narrative, and neurobiological objective. From the standpoint of the supervisory relationship, self-disclosure conveyed to Anna I was a person willing to be vulnerable with her and share my emotions with authenticity (Knight, 2012; Prenn & Fosha, 2017). My disclosure let Anna into my process of meaning making, an essential move in narrative therapy (White & Epston, 1990; Zimmerman, 2018).

My admitted struggle revealed my transformed internal narrative, which moved from not being "good enough" to being "good enough to supervise" (Carr, 1998; Zimmerman & Beaudoin, 2015). Finally, validating and responding with empathy to Anna's distress was a direct interpersonal neurobiology intervention (Siegel, 2012) directed toward soothing her shame in the hope it would soothe her nervous system as well. Although this is not a measurable intervention in this context, the literature certainly supports this conjecture. I waited and gave Anna time to take in her experience and then asked permission to explore how my disclosure felt for her. She resumed eye contact and said she felt relieved. When I prompted her to continue, she added, "I can see it was also hard for you in the beginning. That feels awful, but it is also hopeful for me in a way because you clearly know what you are doing now." Anna smiled and added, "I hope!" I laughed along with her adding, "I hope so too!"

This brief moment relates to the narrative therapy technique of inciting non-conscious influence (Zimmerman, 2017). Non-conscious influence is based on the assumption that sharing one's personal story allows for "mutual multiple states" (Zimmerman, 2017, p. 20). Non-conscious influence posits that interactions carry emotional affect rooted within a person's memory. Here, the goal of self-disclosure was aimed toward connecting Anna's lived experience of imposter phenomenon with my early experiences of self-doubt. Through the phenomenon of non-conscious influence, Anna attuned to my sadness and experienced empathy for me, which in turn allowed her to feel

some degree of hopefulness for herself (Zimmerman, 2017). Though subtle, we connected through our shared genuine emotions and, as evidenced in the neuroscience literature, our right-brain connection evoked a slight change (Cozolino, 2006; Miehls, 2014; Prenn & Fosha, 2017).

Our shared emotional experience fostered attunement and empathy for self, both of which are necessary to undermine the overwhelming sense of failure inherent to imposter phenomenon (Cozzarelli & Major, 1990; Thériault & Gazzola, 2010). As our first meeting came to an end, I once again, neutralized my privileged position as supervisor and reinforced the foundational narrative therapy framework of Anna as the expert on herself (Carlson & Erickson, 2001). I asked Anna if she wanted to schedule another supervision session. She looked surprised, let out a sigh and let me know she had felt very isolated since making this career change and wanted to meet weekly. As Fosha (2000) so eloquently stated, "undoing unbearable aloneness" (p. 82) is the first step toward transformative healing. Whether the journey is emotional, cognitive, or spiritual, it is the connection that makes it safe.

Over the next few weeks Anna and I collaborated on a living supervision contract. We discussed her learning goals and boundaries, and our respective responsibilities for supervision. I defined for Anna how I integrate interventions from narrative therapy and interpersonal neurobiology into my approach to supervision. My intention was to lessen her anxiety and honor her professional equality within our supervisory dyad. I discussed how countertransference, emotional activation, and Anna's attachment history would be contextualized within the framework of her practice with couples. Distinguishing supervision from psychotherapy is essential and a foundational component of supervision that actively engages with a supervisee's raw emotions (Frawley-O'Dea & Sarnat, 2001; Miehls, 2014; Prenn & Fosha, 2017). With the seeds of our supervisory alliance planted and the intentions and limitations of our work collaboratively defined, Anna and I began our ten-month journey toward learning and healing.

As Anna and I began watching her couple therapy session tapes, we saw how Anna's imposter feelings were activated whenever her clients experienced shame, despair, or hopelessness. In one of Anna's sessions, she became overwhelmed by her clients' reactivity and sat silently as the couple argued throughout the session. Anna described feeling mortified by how she "was useless" and "did nothing but fake it" while her clients struggled. I guided Anna through a series of yogic breathing exercises (Lin et al., 2020) and cued her to scan her body for sensation. She identified feeling a heavy weight in her chest, which she described as a block of ice. Cozolino (2006) found that somatic activation occurs when the nervous system reacts to stimuli, which in this moment was her inaction with her distressed couple. Exploring Anna's somatic experience theoretically connects left-brain processing – what Anna was doing in her session, to right-brain emotional reactivity – what Anna was

feeling as she watched her session (Cozolino, 2006; Shapiro & Applegate, 2018). Working with the body through somatic markers also served as a doorway to Anna's oppressive narrative, which in the moment was "I am a useless fake." In keeping a narrative therapy focus, I initiated a series of questions to externalize the problem, starting with, "How is that block of ice weighing you down?" This question introduced the possibility of a separateness between Anna and her block of ice and helped Anna begin to recognize her imposter triggers. The narrative therapy technique of externalizing the problem created space for Anna to move through her paralyzing shame of fraudulence, "useless fake," and identify the onset of imposter feelings via somatic markers in her body (Prenn & Fosha, 2017; White & Epston, 1990).

In the months that followed, I had Anna keep a journal and share one story each week of children she helped in her previous career. Anna shared her vignettes about children she counseled through chronic illness, divorce, parental and sibling loss, and foster care. As she shared, I asked Anna to scan her body and notice how it was responding to her stories of helping children heal. She described having more "space in her chest" and attributed it to the "ice melting." Rather than merely having her tell about this shift, I explored it with her experientially in order to help her expand her emergent new narrative. Anna was creating a new narrative from actual lived, embodied experiences with the children she treated (White & Epston, 1990). She embraced this intervention and became increasingly connected to her prior competence while becoming more somatically aware of how imposter phenomenon was triggered in her body. She continued to be triggered by intense client affect but was able to recognize it.

A crucial aspect of Anna's new story was joining her couple therapist identity with her child therapist identity. In one session, she became overwhelmed by a client raging at his wife. I prompted her to think of how she would intervene with children. She did not hesitate, and expertly rattled off several interventions: validate their emotions, use a calm voice, and put language around what they need in the moment. She began to see that no matter what the couple therapy trigger was, the child therapist in Anna had the answer. Together, Anna and I brainstormed how she might integrate those interventions for appropriate use with her couples, then role-played her adaptation. As Anna and I moved through the role play, Anna described feeling lighter in her body. Anna connected to a part of herself she believed was competent, but whose voice had been stifled for many months by shame.

As previously stated, Roth et al. (2013) found shame and guilt to be registered in the brain similarly to that of a physical threat. In that same study, they observed that pride elicited a "stronger brain activity than shame and guilt" (p. 102) in the amygdala, where emotional processing occurs (Roth et al., 2013). Taken together, the findings of Roth et al. (2013) and the neuronarrative theory of Zimmerman (2017) suggest that Anna's neural response to

pride would be greater than that of her shame. In addition, linking Anna's perceived incompetence with couples to her success with vulnerable children helped her create a preferred narrative through a lived experience of prior mastery. The resulting corrective emotional experience is referred to by this writer as r*eclaiming disowned competence*. It is designed to disrupt feelings of incompetence and fraudulence brought on by imposter phenomenon. Slowly and purposefully, Anna continued to transfer her experience working with children to her learning of couple therapy. In turn, she became less reactive and self-deprecating. Anna's emotional reactivity lessened and her willingness to risk in the pursuit of learning increased. Though she still struggled to respond to couple reactivity, Anna was better able to tolerate intermittent feelings of incompetence and anxiety. Anna began to believe that enduring a certain amount of skill deficit was an understandable part of clinical learning.

In the latter part of our work together, Anna began seeing a highly distressed couple on the brink of divorce after the discovery of the husband's affair. Anna felt tremendous pressure to help them through this crisis and was highly concerned about the effect of the couple's distress upon their four young children. Anna presented a segment of her most recent session with this couple in a supervision session. The wife was sobbing and grieving the painful betrayal and loss of trust. The husband had his back to his wife, flushed with shame, tearful, and unable to face his wife's overwhelming pain. I watched admiringly as Anna struggled to engage with each of them. I witnessed Anna put language to each of their experiences, validate their pain, gently probe for their unexpressed needs, and hold each of them emotionally. She continually checked in with the child therapist in her to see what to do next. It was a challenging session for Anna, but she did not "freeze" as she had for so many months in similar scenarios.

I was incredibly moved by Anna's work. Just a short time ago, intervening in a similar situation would have felt perilous for her. Anna stopped, looked at me, and noticed the explicit emotion on my face. She assumed I was experiencing an empathic response to her couple and said as much. Rather than take the exit Anna unknowingly provided for me, I decided to do what I had been trying to help Anna do in supervision: trust and risk. In a soft voice and with unwavering eye contact I said, "I was moved by you Anna. You stayed with everything they were feeling and helped them to see each other's pain. That was a beautiful piece of work." Anna's eyes began to moisten. I waited. I gave her time to take in my words and feel into her experience. Then, as always, I asked her permission to explore how my disclosure felt for her. She remained silent allowing her truth to emerge. After a few moments, she smiled and said, "I feel like you see the me I used to be. You have known the frozen part and now you are starting to see the true me." Anna reclaimed her identity as a competent professional. She embodied her new narrative, which transformed the imposter within and helped her break through her own wall.

In the ensuing months, Anna and I continued to explore her "frozen" part and her "true me" part. We enacted dialogs between them, role-played, and adapted her experiences to interventions she could practice with her clients as she expanded her new narrative. Anna and I continued to build a cadre of emotional experiences and integrated them into her couple therapy work. In the last three months of weekly supervision, Anna reported a "significant ease" in her physical symptoms, insomnia, and anxiety. Anna gained enough confidence to make mistakes in the service of learning, take bigger risks, and try new interventions with her clients.

Together, Anna and I created a mentorship where she could receive empathy and validation, and experientially work through her shame and fear. Our relationship became one of transparency, emotional support, and somatic awareness, all of which shifted Anna's self-perception from shameful imposter to self-compassionate learner. Eventually, Anna was able to transition from individual supervision to a collaborative supervision group where she regularly presented her work to therapists training in couple therapy, while giving caring feedback to her peers. At the conclusion of individual supervision, Anna had overcome feelings of incompetence and shame, become more proficient in couple therapy, and found gratification and joy in her new practice. Anna reached out to me when she finished her program and received her certificate in couple therapy. With an ebullient chuckle, similar to what one might hear from a child who just lost her training wheels, she said, "I am a real couple therapist."

Discussion

Anna's case study illustrates the effectiveness of using narrative therapy to support neuroplasticity and ameliorate imposter phenomenon (Zimmerman & Beaudoin, 2015). Supervision within a bonded, non-hierarchal relationship driven by mutual emotional engagement can serve as a modality for healing and learning. This case report adds further evidence to the need for psychotherapy supervision to support clinicians' well-being not merely provide didactic feedback and theory. As neurobiology and interpersonal emotional engagement gain prominence in clinical supervision, the lines between supervision and psychotherapy can become blurred (Frawley-O'Dea & Sarnat, 2001; Miehls, 2014; Shapiro & Applegate, 2018). As such, all emotional processing related to imposter phenomenon must be theoretically contextualized and connected back to its relevance to the supervisee's learning experience (Frawley-O'Dea & Sarnat, 2001; Miehls, 2014; Prenn & Fosha, 2017; Wooley et al, 2014).

I chose not to probe or explore the possibility that Anna's dysregulation with intense vulnerability may not only have been connected to imposter phenomenon, but to countertransference related to her childhood loss of her

father and her mother's depression. Though she did not divulge such feelings, it may have been helpful for me to ask. I was concerned that exploring Anna's childhood might make supervision feel too much like therapy. Further research is needed to address this gap in order to solidify the teach-treat boundary and ensure supervisee safety. That said, given the paucity of literature examining the impact of imposter phenomenon upon psychotherapists and the absence of evidenced-based methods of supervision to address it (Urwin, 2017), this case report provides a foundational first step toward future research.

There is significant promise in the coupling of narrative therapy and neuroplasticity in supervision and beyond. Researchers are examining how different models of practice are supported by neuroplasticity through an interpersonal context. Zimmerman's (2017) Neuro-narrative therapy represents his approach to the potential of using narrative therapy techniques to support neurogenesis. Shapiro and Applegate (2018) have published a trailblazing text specifically geared toward expanding psychotherapy practice through neurobiology, while Miehls (2014) has begun a trend examining the potential of a neurobiological framework for clinical supervision.

Research substantiating the power of interpersonal neurobiology to enact emotional healing offers many alluring pathways through which psychotherapy supervision and training can ameliorate emotional distress and promote resilience. Future research may include a multiple case study examining the supervision experiences of the five subjects upon whom this composite case report was based. An interpretive phenomenological analysis could provide a deeper understanding of the lived experiences of psychotherapists suffering with imposter phenomenon. The development of a formal model of training for supervisors interested in integrating narrative therapy techniques and interpersonal neurobiology into psychotherapy supervision would advance the field while providing an invaluable resource for clinicians and students alike.

Conclusion

Anna's experience with imposter phenomenon was painful and affected her perception of self-worth and professional efficacy. Anna benefited from supervision using narrative therapy informed by interpersonal neurobiology. She regained confidence, felt less shame and fear, and cultivated self-empathy through the creation of a new internalized narrative. As researchers continue to examine imposter phenomenon, it is imperative to address this problem much in the way studies examine compassion fatigue, burn-out, and self-care. Collaborative research between the fields of psychotherapy, supervision, and neuroscience may hold promise for developing methods to further support the emotional well-being of clinicians. Finally, examining the effect of imposter

phenomenon upon clinicians who are also part of an oppressed or marginalized group can serve to alleviate suffering and advance the cause of social justice. As clinicians, educators, and engaged scholars, we have a duty to support all clinicians as they struggle in service of others.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Angela DeCandia Vitoria approaches teaching and social work supervision as endeavors of equality and social justice. Before becoming a social worker, she taught English to special needs high school students and first-generation college students from underserved communities. She is a founding member of The New York Center for Emotionally Focused Therapy (EFT) and served as the Director of Community Outreach, creating multiple programs to bring pro bono education and training to social workers treating marginalized and oppressed populations. She and her colleagues developed a formalized model for EFT therapy supervision and coauthored Training the Emotionally Focused Therapist in *Couple, Marriage and Family Therapy Supervision*. Angela is a Give-an-Hour volunteer providing therapy to post-deployment veterans struggling with PTSD. She is a doctoral student at Rutgers University and maintains a private practice in Montclair, NJ, where she specializes in working with couples, families, and individuals struggling with depression, PTSD, infant death, and complicated grief.

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